MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Wednesday, January 16, 2002
9:34 a.m.
And
Thursday, January 17, 2002 - begins page 29
8:33 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item:
Assessing payment adequacy and updating Medicare payments, continued: outpatient dialysis services, skilled nursing facility care, home health services - January 16, 2002
Nancy Ray, Sally Kaplan, Sharon Bee

MR. HACKBARTH: The next item on our agenda is assessing payment adequacy and updating Medicare payments for outpatient dialysis, skilled nursing facility care, and home health. Nancy?

* MS. RAY: Thank you. I am here to discuss updating payments for dialysis services for 2003. The general purpose of the update is to implement a compensating adjustment if payments are too high or too low, and to provide for payments to change at the rate of efficient providers' costs.

The reason that we care so much about the update is that we want to ensure that beneficiaries continue to gain access to high quality care.

So parallel to the Commission's update framework, my presentation is divided into two parts. In the first part we look at evidence about payment adequacy. In the second part, we look at how much efficient providers' costs are expected to change in the coming year. As you recall, the two parts of our update framework can possibly each result in a percentage change, which are then summed to determine the final update recommendation.

I conclude my presentation with a draft recommendation about updating payments in the coming year.

This graph shows the most current data that we have about Medicare's payments and providers' costs. The new data point on this graph that you haven't seen before is the payment-to-cost ratio for composite rate services and separately billable drugs in the year 2000. We calculated that to be 1.05. As you can see from the graph, payment-to-cost ratio for just composite rate services dropped from 0.98 in 1999 to 0.96 in 2000. The broader payment-to-cost ratio also dropped by two percentage points, we think primarily because the composite rate in the year 2000 was updated by less than market basket, 1.2 percent, and there was a price increase for erythropoietin by 3.9 percent.

A couple of other points I'd like to talk about, about this graph. First of all, these data are for freestanding dialysis facilities only. Hospital-based facilities represent about one-fifth of all facilities. There is no evidence that we are aware of any differences in patient acuity between freestanding and hospital-based facilities.

The other important point is that the four data points you see on that graph, they represent unaudited data. HCFA has not regularly, on an annual basis, audited cost report data. BBA required CMS to audit cost report data and they did so with the 1996 cost reports.

So this raises the issue that has been raised before about

Medicare allowable costs. The cost reports are supposed to include only Medicare allowable costs. The four data points you see are unaudited, and to a certain extent they probably do include non-allowable costs. The effect of auditing the data and pulling out those non-allowable costs would be to raise the line. If you wanted to include non-allowable costs, then you would be lowering the four data points.

I guess I just raise that as an issue for you to consider. I don't propose, at this point, to make any adjustment to the data points that you see there. The treatment of non-allowable costs, how we treat non-allowable costs when we examine payment adequacy is a cross-cutting issue. I think staff are planning to do additional work on this topic and at this point we would like to defer any final action on how we treat allowable and non-allowable costs for the future.

Our findings that payment for dialysis services did not cover providers' costs could imply that payments are too low or that costs are too high. Many experts believe that Medicare overpaid for dialysis services for much of the '80s and even into the '90s. It appears, at this point, that providers' costs for composite rate services have caught up with Medicare's payment rate. Congress only updated the payment rate once during the 1990s, by $1 in 1991.

We conclude, in your briefing paper, that costs for composite rate services do not appear to be inappropriate.

Our finding that payments for injectable medications not included in the payment bundle significantly exceeded providers' costs between 1997 through 2000 could imply that payments are too high or costs are too low. In this case, it is highly probable that Medicare pays too much for certain of these injectable medications. GAO and OIG have concurred with our finding about this.

So what's going to happen after 2000? We do not really know how dialysis costs for composite rate services have changed in 2001 or will change in 2002. Consequently, we assume that providers' costs will increase at about the same rate as the market basket.

Just as an FYI, Congress did not update the composite rate payment in 2002. Last year your recommendation was not to update it for 2002. And current law does not include any update to the composite rate for 2003.

The other factor that we do know that's going to happen in 2001 is that the price of EPO went up again. The manufacturer raised it again by another 3.9 percent.

We estimate that the payment-to-cost ratio will drop roughly by two percentage points in 2002 if we assume that composite rate costs continue to increase at the market basket. And the split between the composite rate payments and separately billable drugs remain at that same split, which is roughly 61 percent to 39 percent. And three, that the payment margins for other

separately billable drugs stay at the 2000 margins. Again, there's some tenuous assumptions there, but I think it will give you a feel for what might happen in 2002 if the composite rate is not increased.

MR. HACKBARTH: So, Nancy, you're saying that the best guess, with qualification, with some uncertainty, is that the payment-to-cost ratio went down by 2 percent each for the two lines. So for the composite rate only it would be 2 percent lower. And for the composite rate plus separately billable drugs, that would also be 2 percent lower?

MS. RAY: No, the last estimate for 2002 is the broad-based ratio, the composite rate and separately billable.

MR. HACKBARTH: So if that's at 1.05, you're saying our best guess is it would be 1.03 for 2002?

MS. RAY: Yes.

DR. NEWHOUSE: Nancy, do you know when the original formulation of erythropoietin is going off patent?

MS. RAY: I don't know that, and I think what's very tricky about that is because -- and again I'm not an expert on this -- but because it's a bioengineered drug, there may be patents on the manufacturing process, as well as on the drug itself. I can look into that.

Now there is a new drug that has just been approved. The same manufacturer who makes erythropoietin is making this new drug. It's a once a week EPO.

DR. NEWHOUSE: I know. That's why I asked about the original formulation. I thought it was about to go off patent.

DR. REISCHAUER: The letter we got said, for some years to come that it was still on patent.

MS. RAY: I can look into that and get back to you on that.

MS. BURKE: Nancy, I'm just interested in this. Do I recall that initially the acuity of patients in the inpatient or the hospital-based facilities, as compared to freestanding, was in fact different? Has that changed? You noted that they appeared to be quite similar.

MS. RAY: There is no recent evidence of any difference in patient acuity. It's my understanding, but again I wasn't around back then when the composite rate was originally set, was that the difference in the base payment rate was a difference in providers' costs.

DR. ROWE: There may be a distinction here, Sheila, that maybe isn't clear. First of all, I think that Nancy is speaking about dialysis facilities that are attached to hospitals.

MS. BURKE: I understand that.

DR. ROWE: As opposed to inpatients who are being dialyzed.

MS. BURKE: I understand.

DR. ROWE: The inpatient is being dialyzed, there would be an acuity. In addition, we're only talking about Medicare beneficiaries and thus, the acute cases would not yet -- unless they're already over 65 and a Medicare beneficiary -- they would

not yet be in the ESRD program.

MS. BURKE: Sure they would.

DR. ROWE: No, if you're a 45-year-old and you get acute renal failure and you're insured by Aetna, Aetna pays for your dialysis.

MS. BURKE: If you're just acute. But if you're acute disabled, your Medicare.

DR. ROWE: For the first 30 months, not three months.

MS. BURKE: Unless you triggered into disability and then if you're DI then you qualify for Medicare, you kick in.

DR. ROWE: I was surprised also when I heard this, but I was just thinking that maybe it's because my bias is that the inpatients are part of the hospital program.

MS. BURKE: I'm literally recollecting back to the late '70s, early '80s when I recall, for some reason, that the hospital-based non-inpatient patients had a higher acuity. But my recollection may be wrong.

MS. RAY: I really can't comment about the late '70s, early '80s.

[Laughter.]

MS. RAY: What I can say is that I haven't --

DR. ROWE: Don't say anything.

MS. RAY: There's just one point I want to make about this 2002 prediction, why I think it's tenuous. That is because it's based on the split between payments for composite rate services and separately billable drugs. We've seen, in the last four years that we have data, the significant growth in the use of separately billable drugs. To the extent that they continue to increase that, of course, will affect margins.

We look at other factors to assess payment adequacy, in addition to the margin data. We talked about this at the December meeting. We look at changes in the product, and again we discussed this in December. We have seen, in the '90s, more in-center hemodialysis versus peritoneal dialysis occurring, even though costs for peritoneal dialysis are less but the payment rate is the same.

We have seen, like I just said, about the significant increased use in separately billable drugs. For example, for drugs other than erythropoietin, allowed charges went from $281 million in 1997 to about $605 million in the year 2000.

Now this has come with continued improvements in quality of care. There is concern, however, that because these are cost-based payments there is the potential for inappropriate use.

We talked about provider entry and exit and we discussed the increasing number of facilities opening. There was a question about is there sufficient capacity. I tried to look at that in terms of average stations per facility, average treatments per facility, and treatments per dialysis station.

It appears to me, the conclusion I drew from this information, is that these three figures have stayed relatively

constant between 1993 through 2000, and that capacity has increased by building more facilities rather than expanding existing facilities. The best I can say is that, linked with the fact that we haven't seen any systematic problems in access to care, would lead me to believe at this point that capacity is sufficient.

And the other issue that is new to this slide is that we did look at differences in facilities that stayed open between 1993 to 2000 and facilities that closed. Where you saw differences, facilities that closed were more likely to be hospital-based and to be small, to provide fewer number of dialysis treatments and have fewer number of stations. There were very small differences between the facilities that stayed open and closed in treatments paid for Medicare or by location.

MR. HACKBARTH: Nancy, on that last point, are you saying that there is no evidence that facilities that treat more Medicare patients were more likely to close?

MS. RAY: Right. I just did not see that. The facilities that were more likely to close, and where you see the big, big difference, is if they were hospital-based they were more likely to close and if they were smaller.

Based on the information about payment adequacy therefore, staff conclude that total outpatient dialysis payments are not inadequate. At the end of my presentation, and once you start discussing this, I would ask that you explicitly discuss that conclusion. The update recommendation is, of course, predicated upon that conclusion.

Like Tim spoke about earlier today, CMS has not yet developed a market basket index for dialysis. They're currently doing so. They're supposed to have that report to the Congress July of 2002.

We have our own market basket. The market basket uses information from price indices for PPS hospitals, SNFs, and home health. Using our market basket, we estimate that costs will rise 2.4 percent between 2002 and 2003.

So that leads us to our draft recommendation. This draft recommendation is that for calendar year 2002 the Congress should update the composite rate for outpatient dialysis services by 2.4 percent to account for changes in input prices in the coming year. This is based on staff's conclusion that payments are not inadequate and that we are not taking any adjustment because of payment adequacy.

DR. ROWE: This is a change in the 2.6 percent that you sent out.

MS. RAY: It is, yes. And that's because I used fourth quarter data, which is more recent data than the last time. Thanks for noticing.

MR. HACKBARTH: Comments or questions for Nancy?

DR. NELSON: Nancy, I certainly support the recommendation, although I like the 2.6 better. But I want to comment on the

injectable medications and some of the assumptions that seem to be made based on volume. Indeed, the increase in volume of injectables may be perfectly appropriate. Unless there's some evidence that they're exceeding clinical guidelines, I'd hesitate to draw conclusions.

Furthermore, if I put myself in the position of a patient that is confronted with either receiving medication in an IV that's already in place or getting a shot every time, or either having vitamin D intravenously or having to come up with $10 a month to buy it as an uncovered benefit, it's easy for me to justify the increased volume of injectables based on the patient comfort and perhaps even the quality of care, rather than just being something related to compensation.

MS. RAY: One piece of information from the audience. The audience person says the EPO patent extends until 2014.

DR. ROWE: Isn't that a long time? How long is it usually?

MR. DEBUSK: 17, now it's up to 20.

MS. RAY: It was approved in 1989, that I do know. I'm pretty sure about that.

MR. HACKBARTH: Other comments or questions?

Nancy asks that, although it wouldn't be a recommendation, that we specifically address whether the existing payments are adequate. I take it our best estimate of 2002 is about 1.03 for the payment-to-cost ratio for composite services plus separately billable. It sounds to me that that falls within our range of adequacy. Any disagreement with that?

DR. REISCHAUER: Remind me, what is our range of adequacy? I'm sorry.

MR. HACKBARTH: We have not adopted a specific numeric range.

DR. REISCHAUER: Then I think this does fall within the range.

MR. HACKBARTH: Thank you for that contribution, Dr. Reischauer.

[Laughter.]

MR. HACKBARTH: Okay, are we ready to vote? Are we prepared to vote?

All those opposed to the draft recommendation?

All in favor?

Abstain?

Great. Thank you, Nancy. Next is skilled nursing facilities.

* DR. KAPLAN: Good afternoon. As Glenn said, we're going to talk about payment adequacy and updating payments for skilled nursing facilities. At the end of my presentation you'll need to recommend how SNF payments should be updated for fiscal year 2003.

We have three key questions to consider today, whether the base payment is adequate, whether the distribution of payments is appropriate, and what the update should be. The answers to these

questions are complicated by not knowing whether CMS will refine the RUG-III, the SNF classification system that hasn't been effective in distinguishing among patients and resources needed for care. Whether RUG-III is refined or not will affect payments.

We looked at a number of indicators to assess payment adequacy, one of which was Medicare margins. To model estimated SNF costs and payments for fiscal year 2002, we used the same method as used for the hospitals. We used fiscal year 1999 as the cost base. We increased costs by market basket for 2000 through 2002. And increased payments by update factors. Because we're making a recommendation for payment in fiscal year 2003, we modeled payments and costs with payment policy that will be in effect in that year.

As you know, Congress enacted a series of temporary rate increases for the SNF PPS. We've given these add-ons names so everyone can be clear about them and what we did with them in the modeling. We found it very confusing and we were constantly having to explain them, so we've given them names. We've named them add-ons X, Y and Z.

None of the add-ons was in effect in 1999. Add-on X was a 4 percent increase across all the rates. Add-on Y was a 16.66 percent increase in the nursing component base rate. Both add-on X and Y expire in fiscal year 2003. We did not include either of these add-ons in our modeling as a result.

Congress put add-on Z in place to give CMS time to refine the RUG-III. This is a 6.7 percent increase in rates for rehabilitation patients and a 20 percent increase for medically complex patients.

DR. ROWE: Sally, when you say they expire in fiscal year 2003, does that mean they expire at the end of 2002 or at the end of 2003?

DR. KAPLAN: At the end of 2002. As of September 30, 2002. That's under current law.

CMS has signaled their intention to refine the RUG-III but we don't know whether they will accomplish this task. Therefore, we've modeled 2002 payments with and without add-on Z.

Our estimates of costs for 2002 are likely overstated because we use the first year of the PPS as the cost base, fiscal year 1999, and we increase costs by full market basket after 1999. We made no adjustment for behavior change. However, experience with other PPS' suggest that SNFs continued to cut costs as they had more experience with a PPS.

We know that hospital-based SNF costs are overstated because hospitals allocate some costs to their SNFs, they have a higher case-mix, and appear to have a different product than freestanding SNFs.

To come up with our best estimate of hospital-based SNF costs we started with freestanding SNF costs because they are able to deliver SNF care under the PPS. We also considered the

difference in case-mix and product for the two types of facilities. Hospital-based SNFs had an 11 point higher case-mix compared to freestanding SNFs in 1999 according to our APR DRG analysis that we reported on last year and since.

Hospital-based SNFs also appeared to have a different product than freestanding SNFs. They have a different staff mix, more licensed staff, and an average length of stay about one-half that of freestanding SNFs. After increasing costs for case-mix, we added half the remaining difference in costs, and that may be on the high side. Our best estimate is that reasonable costs for hospital-based SNFs equal freestanding SNFs costs plus 30 percent.

The table on the screen shows the Medicare margins estimated for 2002. First, I'd like you to focus on the line for the margin for all SNFs, which is in blue. Just as a reminder, in 1999 no add-ons were in effect. As you can see, the Medicare margin for all SNFs is about 5 percent with add-on Z. Without add-on Z, the Medicare margin drops to almost negative 5 percent. Add-on Z represents about a 9 percent increase in payments.

The Medicare margin for all SNFs for 2002 suggests that the base payment rate is adequate with add-on Z. Without add-on Z, the base appears to be inadequate. The other factors we examined also suggest that the base rate is adequate. Freestanding SNFs are staying in the program, beneficiaries have had stable access to care in 2000 and 2001, and most SNFs appear to have access to capital. A study by the National Investment Center for Seniors Housing and Care Industries indicates that independent SNFs and small to medium-sized regional chains, which together represent 47 percent of the market, on average were able to increase their net operating income and debt service coverage from 1998 to 1999.

DR. BRAUN: Are the X and Y add-ons taken out of the modeling for 2002?

DR. KAPLAN: X and Y were never included in the modeling. The modeling is 1999 and 2002 with 2003 policy. So they're not in the modeling at all, X and Y.

MR. HACKBARTH: Sally, I'm sorry, could you repeat what you said about debt coverage?

DR. KAPLAN: Yes, I can. The National Investment Center for Seniors Housing and Care Industries did a national study. They indicate that independent SNFs and small to mid-size regional chains, which together represent about half of the market, were able to increase their net operating income and debt service coverage from 1998 to 1999. They increased it from about 11 to 12 percent to above 14 percent on the net operating income.

MR. HACKBARTH: That's for their whole book of business, Medicare and Medicaid?

DR. KAPLAN: Yes.

We have the same table on the screen now, but we've highlighted the margins for the two types of SNFs this time. The margins are very different, as you can see. With add-on Z,

freestanding SNFs have an estimated 9.4 percent Medicare margin in 2002. Without add-on Z, these SNFs still have a positive margin but it drops to 0.4 percent.

Hospital-based SNFs, even after accounting for differences in case-mix and product, have very low margins, minus 21 percent with add-on Z, minus 33 percent without the add-on.

Assuming that add-on Z remains in place, the margins and other factors we examined in assessing payment adequacy suggest that the payments are more than adequate for freestanding SNFs. Payments appear less than adequate for hospital-based facilities. The continuing departure of hospital-based SNFs from the Medicare program and negative margins beyond what we would expect suggest payments are not adequate for these facilities.

However, even with these negative margins, hospitals still have an overall Medicare margin of 3.8 percent, as you'll remember from earlier this afternoon. SNFs represent 2 percent of hospital payments.

MR. HACKBARTH: Sally, remind me, is the hospital-based row here after some adjustment for cost accounting.

DR. KAPLAN: Yes. We basically, instead of taking the cost accounting out, what we did is we started with the freestanding's costs and then added for case-mix and product difference. Basically, these rates are freestanding costs plus 30 percent.

MR. HACKBARTH: So this is our best estimate of the real economic situation?

DR. KAPLAN: Yes, that's our best estimate of reasonable costs, was the way that we described it.

To account for cost changes in the coming year we begin with market basket. We expect SNFs to continue finding additional ways to cut costs under the PPS. The phase-in, which ends in fiscal year 2002, was designed to give facilities time to adjust gradually to the PPS. We think they will continue to adjust in the coming year, even after the phase-in is complete.

Now we will review our conclusions. If add-on Z expires, payments won't be adequate. Therefore, it appears that the add-on Z should be incorporated into base.

Freestanding SNFs' Medicare margin of 9 percent and their continuing in the program suggests the payments are more than adequate. Therefore, they do not appear to need an update.

Even after the adjustments we've discussed, hospital-based SNF payments appear to be less than adequate. This suggests payments should be updated by market basket and that money should be added to the base rate pending development of an effective classification system.

The draft recommendations are on the screen and collectively, the last three provisions -- the things shown by bullets -- are essentially equivalent to market basket minus 1 percent.

DR. ROSS: If I could just clarify, that very last bullet is subordinated to for hospital-based facilities.

DR. KAPLAN: Basically we're going to update the payment rate amount by market basket for hospital-based facilities, not freestanding.

DR. ROWE: Do you have total margins in addition to Medicare margins? This is one of the kinds of facilities where we really got into the question of Medicaid and Medicare and the balance, et cetera.

DR. KAPLAN: I don't have them on a slide. I have them for the freestanding SNFs.

DR. ROWE: What are they?

DR. KAPLAN: Negative 2 percent.

DR. ROWE: So the total margin is negative 2 percent, including this Medicare margin?

DR. KAPLAN: Yes, everything.

DR. ROWE: You don't know what it is for the hospital-based?

DR. KAPLAN: Because you would get the most of Medicare margin that you get in the hospital base, which is 3.8 percent.

DR. ROWE: I was just looking for the SNF itself rather than for the whole hospital.

DR. KAPLAN: Their margin would be their Medicare business for the SNF. I mean, that would be their total margin. Most of the hospital-based SNFs don't take any Medicaid.

DR. ROWE: Or private.

DR. KAPLAN: No. They might have some commercial, but...

MR. SMITH: Does the first paragraph of the recommendation refers not to add-ons X, Y and Z, but only add-on Z; is that correct?

DR. KAPLAN: That is correct.

DR. NEWHOUSE: How would I know that?

MS. RAPHAEL: You know that because that one is tied to when the refinement of the classification system occurs. When that's declared refined is when add-on Z is due to expire; right?

DR. KAPLAN: Right. We didn't think the Congress would know what add-on Z was so basically -- I'm sorry, it's true. So this is the only add-on that was specifically put in place to allow CMS time to refine the RUGs and expires when CMS states that the RUGs are refined.

MS. BURKE: I'm sorry, I want to make sure I understand this because of the variance between hospital-based and freestanding. It is your intention to retain, for all facilities, the current temporary adjustment. It is then your intention to provide an update, market basket update only for the hospital-based? Correct?

DR. KAPLAN: That is correct.

MS. BURKE: So let me understand bullet two. In bullet one, you're saying you freeze the base. That's freezing the base with the current temporary adjustment. Point two is for the hospital you freeze the base, which includes the temporary, plus you add 10, plus you add market basket?

DR. KAPLAN: That's correct.

MS. BURKE: Then point three, update the base by market is only for hospital-based?

DR. KAPLAN: Right, and you included that when you were rephrasing bullet two. They're getting a market basket update plus 10 percent.

MS. BURKE: Right. Can I simply suggest that you might want to think about you rephrase this so it's explicit? It may be I'm just show in getting it.

DR. KAPLAN: Also part of the confusion is because the last bullet should say for hospital-based facilities.

MS. BURKE: Right, but make it explicit that it is our understanding -- and I mean you do sort of in that opening paragraph, but say the presumption is that the temporary adjustments remain in place which equal X percent, and that we assume that's the base. And it's on that base we then build.

MR. SMITH: But in that regard it does seem to me we need to be clear, at least so we understand, maybe Congress will or won't, that at the moment if somebody looks at the payment structure there are three temporary payments. We're only talking about rolling one of them into the base and we need to say that in a way that someone who now thinks there are three doesn't think we're talking about three.

MR. HACKBARTH: I just need a clarification on what Sheila just went through. So the second bullet, increase the base by 10 percent until an effective classification system is developed. What if CMS tomorrow says we've fixed the problem.

DR. KAPLAN: Basically last year, as most of you will remember, we recommended that CMS develop a new classification system for skilled nursing facility patients because of the deficiencies of the RUG-III. And we stated, at that time, that we didn't think it could be refined to be an acceptable case-mix system. We outlined four problems with the case-mix system. And basically, even if they really got it a whole lot better, some of those problems would still remain that would not be solved.

MR. HACKBARTH: With regard to the one temporary payment, didn't Congress vest CMS with the decisionmaking authority about when the system was fixed?

DR. KAPLAN: Yes. It said until the RUG-III is refined. So it did not refer to another classification system.

MR. HACKBARTH: So the first paragraph is driven by CMS' decision about when RUG-III is refined. The second bullet is driven by our judgment about when they've come up with an adequate new system.

DR. KAPLAN: That's correct.

MR. HACKBARTH: That's a little tricky for people to follow. That will need some --

DR. ROSS: You're also on to a point that it's hard to craft a recommendation because we're seeing this currently where if you just leave it to somebody else to say it's new and improved, and they declare it to be new and improved, we couldn't come up with

foolproof language. But I think we can convey the point in the text.

DR. REISCHAUER: Sally, explain to me really what's happening here. Z is an add-on that refers to two categories of folks. When we're saying that we need to build Z into the base, are we talking about the distribution or are we talking about taking that 9 percent and just raising the whole distribution?

DR. KAPLAN: We're talking about raising the base, the whole thing, for all SNFs. And it basically comes out to 9 percent. 75 percent of the patients are rehab patients, 22 percent are in this medically complex, and the other 3 percent are people who never got an increase in rates under this add-on.

DR. REISCHAUER: So then we're basically saying if we do that, I gather, that 9.4 percent margin falls into our range of --

DR. KAPLAN: No. First of all, that leaves everything the way it is. Then, if we do not give freestanding SNFs an update, then that will bring their margin down.

DR. REISCHAUER: Three percentage points or so.

DR. KAPLAN: The market basket forecast at this moment is 2.8 percent but that obviously is subject to change. I used the actual market basket forecast and I came out with about 7 percent, is what their margin would be.

DR. NEWHOUSE: This is a minor change. I think we mean we want to increase the base rate by 10 percent, rather than 10 percentage points, in the second bullet? You can't increase a rate by 10 percentage points.

DR. KAPLAN: Thank you.

DR. WAKEFIELD: Just out of curiosity I want to ask you one question and see if I understood something correctly that you said, Sally. Did you say that most hospital-based SNFs do not take Medicaid patients?

DR. KAPLAN: Yes.

DR. WAKEFIELD: That's because?

DR. KAPLAN: When I say Medicaid patients, I'm referring to custodial patients. I'm not talking about people who are acutely ill that are paid for under Medicaid. I'm really talking about the custodial patients.

DR. WAKEFIELD: Then the second part of that, in the text you indicated that about 20 percent of hospital-based facilities have left the Medicare program. We don't know what of that 20 percent that have left the Medicare program are rural versus urban, do we?

DR. KAPLAN: No, we have not done that work.

DR. WAKEFIELD: In part I'm asking that question because, obviously, a high proportion of rural hospitals provide SNF care.

Just a comment on the text. If this text stays, there's a good paragraph talking about anecdotal evidence that speaks to cost-cutting on the part of SNFs to help hold their costs down using therapy assistants instead of therapists, using licensed

nurses instead of respiratory therapists, et cetera, et cetera. I'd appreciate just a little bit of a caveat in there that says something about we know that they've been effective, it seems, at cutting their costs. We can't say anything about what impact that may have had on quality. So it sounds good on the face of it but I haven't a clue from that what impact, if any, that's had on quality of care.

MR. DEBUSK: If you would, help me understand. I'm a little slow here, Sally. To peel this onion a different way, as I understand it right now, X, Y and Z adds up to about $60 a day. Is that right or wrong?

DR. KAPLAN: At this point I don't know. I've seen that. That's what the industry, but I don't know that.

MR. DEBUSK: Now when X and Y goes away, which it will, of that $60, would I be safe in saying that that would probably leave about $30?

DR. KAPLAN: I don't know.

MR. DEBUSK: I'm trying to figure out, out of whatever they're getting now, what are they going to end up with. It's very complicated, and you wonder what's behind the numbers in going forward. But say it is $60 and $30 comes out of it there. And then we've got Z, and we go into next year, and the stand-alone no longer gets the market basket of 2.8 percent, and what does that translate into? Effectively, what does that reduce that to?

DR. KAPLAN: Instead of dollars, I think the relationship of payments-to-cost is really what we've looked at, rather than straight dollars. And that is that we have not done the work to basically say what it would be, what their margins were with add-ons X and Y in place. I mean, we clearly know they'd be 4 percent higher because there was a 4 percent add-on in place. But the 16.66 percent, which is built into the nursing component base rate, is a lot more complex to figure out.

DR. ROSS: Sally, could I interrupt? Pete, just to follow upon Sally's point, that we haven't done this on a per diem basis but on a margin basis, that table that was up that showed the report of margins in 1999 compared with modeled margins in 2002, the 9 percent was prior to any of these add-ons. The model 2002 is 9.4 or 0.4, depending on what happens to this third add-on.

But the other two to which you refer sort of came and went in the interval. But what we do know is that the margin had to be higher than 9 percent. The reduction in the cost per day, again I don't know exactly what that will be, but payments were certainly in excess of costs before those came along and would have continued to be after them.

MR. DEBUSK: I'm just looking at it trying to work out, in a simple manner, how many dollars are we taking away in the system if all this happens like we propose here? My concern is you know, we really had to bail this industry out at one time, and that's how we got here. And are we going right back there again?

DR. ROSS: There's where you see the draft recommendation, though, is that given the current law possibility that that third add-on be taken away by a declaration of a refinement. And that would leave an essentially zero margin. Where we've argued that no, that money should be locked in.

MR. DEBUSK: Are we talking about 90 percent of that?

MR. HACKBARTH: The whole thing would be put into the base rate. So that's what that first paragraph is about.

MR. DEBUSK: Why shouldn't they get the market basket going forward, as well?

DR. ROSS: That amount of money -- that's a Commission judgment, but that amount of money would put them at a 9 percent margin. I think some might argue, at least on the Medicare line of business, that's beyond the adequate range.

DR. REISCHAUER: But I think what Pete is saying is they were at 9 percent margin in 1999, they then were in deep trouble in 2000 and 2001, and we put more money in. Then we're going to, in a sense, take it back out. Are they going to be in big trouble? But you're saying the big trouble is due to other things.

MR. HACKBARTH: Let's put the issue squarely on the table. I think Jack alluded to it way back at the beginning when we were talking about the issue of what role do total margins play in our decision about Medicare rates. I think it was Bob who suggested that the relevance is if we're going to lose access to Medicare beneficiaries, total margins become relevant to the conversation.

Our best estimate of the total margins is a negative 2 percent. So I think the implication of Pete's point is is that too low? Should we increase the Medicare payments to freestanding SNFs in the name of maintaining access for Medicare beneficiaries?

DR. ROWE: To follow up on that. If we are able to adopt, at least subconsciously, a broader view of financial performance than just margins -- and we've talked about balance sheet stability, financial stability, credit worthiness, et cetera -- it would be interesting to know what has happened and is it happening through this most recent cycle with respect to the credit worthiness of these institutions and their access to capital?

DR. KAPLAN: Their access to capital from '98 to '99 went up for the freestanding, independent, and small to medium regional chains. On the chains, on the large national chains, their net operating income dropped from 17 to 18 percent to 11 to 12 percent from '98 to '99. '99 is your base year here.

So those other two add-ons are on top of that. So it seems to me that --

DR. ROWE: How do you reconcile that with the minus 2 percent number that you gave us?

DR. KAPLAN: I don't necessarily do reconcile it with it. I'm just telling you that that's the study that the National

Investment Center did. They went to the large lenders, the large established lenders that lend to this industry, and looked at their portfolios. And that's what they came out with.

And they compared that to an earlier study that had been done on the large chains.

DR. ROWE: So you're taking these capital issues into account when you give us your impression that the payment rate is not inadequate?

DR. KAPLAN: Yes. Let me just say, I think that it's your decision to decide whether Medicare should cover Medicaid's costs. And my concern would be that that doesn't necessarily give these people any more money, because the more Medicare puts into the pot, it's very possible for the states to back it right out.

MR. HACKBARTH: We've had some people patiently waiting here.

MS. BURKE: Sally, I'm sorry to put this to you again, but I want to walk back for just a second and look at how what I think we're saying is structured and make sure I understand it. It is my understanding that the first paragraph is meant to make permanent as a part of the base temporary adjustment Z; is that correct?

DR. KAPLAN: That is correct. Permanent until it's -- you know, we will be reassessing it every year.

MR. HACKBARTH: But it would be redistributed.

MS. BURKE: I understand. There were three adjustments, X, Y and Z. X and Y are going away. We make no argument that X and Y ought to stay in play.

It is our belief that Z should become a part of the permanent base; correct? Do you, in any scenario, envision Z going away when they rebuild this system?

DR. KAPLAN: I don't think we can answer that because I think that -- all of this is based on 1999.

MS. BURKE: I understand. But for the moment, until we know otherwise --

DR. KAPLAN: Until we know otherwise, it would stay in.

MS. BURKE: We believe Z becomes part of the permanent base upon which we adjust.

DR. KAPLAN: Yes, ma'am.

MS. BURKE: Don't make me feel older than I am. Your highness, your royalness, but not ma'am.

Then I think we ought to say that. It's not clear from reading this that it is our assumption that the other two go away, and what we essentially are incorporating into the base is one aspect of what was a three-part adjuster.

Then I understand what you want to do is you want to make no further adjustment to that base for the freestandings, that's it. That's where they are.

Then you essentially want to do an additional 10 percent increase to the base, permanent for hospital-based?

DR. KAPLAN: No.

MS. BURKE: So it's not a permanent increase?

DR. KAPLAN: No, it's until an effective classification system is developed.

MS. BURKE: Whenever that is.

DR. KAPLAN: Right.

MS. BURKE: But the market basket increase is a permanent increase until everything else is in play?

DR. KAPLAN: Right.

MS. BURKE: Now is it my understanding that the Commission previously stated that a refinement was, in fact, not likely to be adequate? You believe the whole system needed to be replaced?

DR. KAPLAN: Yes, that's correct.

MS. BURKE: So why are we, throughout this thing, talking about all this is good until we refine it if we don't believe it can be refined?

DR. KAPLAN: This doesn't really refer to the refinement, except to say --

MS. BURKE: Yes, it does.

DR. KAPLAN: At the beginning we need a way to refer to this add-on Z. So if the temporary payments implemented to allow the Centers for Medicare and Medicaid Services time to refine the classification system expire, really refers to add-on Z.

MS. BURKE: It seems to me that unless there's a reason not to do this that's historical, we ought to state outright that we continue to believe that the system can't be fixed. That it needs a new system. We ought to just say that and state that outright.

Then it seems to me we ought to say that we believe until such time as it's fully replaced, that this adjustment -- and describe what it is so there's no confusion -- this piece of it ought to be made part of the base until we put in place a new system.

I don't think we ought to look like A, we think a refinement is going to work; or B, that we're not clear about which of those we ought to do, if that's what your intention is.

DR. KAPLAN: All right, I understand what you're saying. Now we don't have a clear statement about add-on X and Y, because of the same reason that Chantal mentioned that generally one doesn't recommend that you follow current law.

MS. BURKE: But in this case we're explicitly providing for the continuation of something?

DR. KAPLAN: Yes, for add-on Z, yes.

MS. BURKE: Which does require a change in the statute.

DR. KAPLAN: Yes, it does.

MS. BURKE: So it seems to me, does it?

DR. ROSS: This is all a little bit more complicated than that, in part because the so-called add-on Z -- this is a contingent. Current law is it stays in place. The issue is whether it might go away if CMS decides to declare it refined

this year. But there's no change in the statute. It can go away or continue with no change in the statute. That was item number one.

Item number two is you're referring to the term permanent.

MS. BURKE: It's just calculated as part of the base.

DR. ROSS: And words like permanent make me nervous.

MS. BURKE: Nothing's permanent.

DR. ROSS: I think the gist of this is that you put this money in place until a new case-mix classification, and presumptively effective class-mix classification system is --

MS. BURKE: But we don't renegotiate this next year in the absence of anything else?

DR. ROSS: Correct.

MS. BURKE: That's my point. Is we presume this stays in the base until such time --

DR. ROSS: But presumably if and when you go to a new PPS, at that point you reassess everything else entirely.

MS. BURKE: My concern is just that it is not our intention, absent a complete reform of the system or whatever we're waiting for, that we're going to renegotiate next year whether or not this adjuster stays in place. This is in place until -- okay. We may want to sort of be overt.

MR. SMITH: On Sheila's point, it seems to me -- I mean, part of the problem I think comes from the use of base because that sounds permanent and we don't really mean permanent. We mean until the inadequate classification system is replaced.

But it seems to me we ought to link that point with what is now the second bullet in the second point. We're talking about two payment adjustments, one for all SNFs and one for hospital-based SNFs, that we believe ought to be incorporated in the base rate until the classification system is replaced. And it seems to me rather than dividing those two thoughts, we ought to get them back together again.

DR. KAPLAN: I think one thing that I'm afraid you're misunderstanding is that this 9 percent, which we're calling add-on Z, we're talking about putting in the base rate for everybody. And I don't like the word permanent either, because we do reassess every year whether the base rate is appropriate or adequate. And we might decide in the future that it's more than adequate.

But then the 10 percent addition to the base for the hospital-based, we're saying that is only until a new classification system, a new effective classification system, is in place.

MR. HACKBARTH: So the triggering events are different.

DR. KAPLAN: Yes.

MR. HACKBARTH: For the first paragraph, a refinement of RUG-III could suffice. CMS says we've tweaked it here and there, it's better than it was. Under current law that means the Z payment goes away. Under this recommendation we would say take

that money then and put it into the base.

DR. KAPLAN: Yes.

MR. HACKBARTH: The second payment, the one that's the second bullet, its elimination is triggered when a whole new classification system is developed. A refinement of RUG-III does not suffice. That is, I think, the confusing part here.

MR. SMITH: But aren't we even more confused, Glenn? Because we're arguing that a refinement of RUG-III shouldn't even trigger getting rid of add-on Z, because we don't think it's possible to do it.

MR. HACKBARTH: The current law, as I understand it, provides that Z will go away if RUG-III is improved, or is declared to be improved.

DR. KAPLAN: Are declared to be improved.

MR. HACKBARTH: So we're saying in the event that happens, and it may happen relatively soon for all I know --

MS. BURKE: Do we think --

DR. KAPLAN: The word on the street is it will be done for 2003, it will be declared as refined.

MR. HACKBARTH: So that's the event that we don't control that we expect to happen relatively soon. In the event it does, we're saying there should be a 9 percent increase in the base. So that money stays in the system, albeit in a redistributed fashion.

We continue to say that we don't think that's enough, enough improvement of the classification. Therefore, there ought to be a 10 percent add-on to the hospital-based until there's a whole new system put in place. That's what we're saying here.

MR. SMITH: I apologize. I am really confused now I think.

DR. NEWHOUSE: Glenn, let me suggest that we get rewritten wording tomorrow.

MR. SMITH: But I think we need to stick with this for a minute and make sure we understand what we'd like to see rewritten.

Sally says that the word on the street is that the declaration will occur before 2003. As this first part of the recommendation is written, that would mean that the 9 percent never got incorporated in the base, it went away.

But that's not what it says.

DR. KAPLAN: No. The word on the street is that the RUGs will be refined for fiscal year 2003. That the refinement will be announced in the proposed rule that comes out this spring and then is put into final rule in the summer, but becomes effective on October 1.

MR. SMITH: But doesn't the first half of the recommendation tell you, as drafted, say in the event that things transpire the way you describe --

DR. KAPLAN: That it actually happens, yes.

MR. SMITH: That the 9 percent then is not incorporated in

the base.

DR. KAPLAN: No, then we tell them to incorporate it into the base.

MR. SMITH: That's not what it says.

DR. REISCHAUER: Why don't we say something like, when CMS refines the RUG-III and add-on Z expires, the resources devoted to this should be added to the base.

MR. DEBUSK: Word in edge-ways. What time? If this is the word on the street, why should we take the market basket for 2003 away from the stand-alone facility?

DR. KAPLAN: Because we're recommending to the Congress that they add add-on Z to the base rate.

MR. DEBUSK: But that's going to go away.

DR. KAPLAN: No, we're recommending to the Congress that they put that money into the base.

MR. DEBUSK: Why do we have to make the market basket go away for this area?

DR. ROSS: Can we break this into two pieces? The first piece of this is an attempt to deal with payment adequacy and basically to lock in what's already there and to prevent it from vanishing. And if we take the suggestion to put it in more direct language, CMS can make the money go away, but I do not believe CMS can make the money come back. So we'd have to craft something that says -- this is where we struggled with the wording -- if CMS makes this go away, then Congress then has to step in and put the money back. That would be item number one.

But that step is the one that will get you to a word of about a 5 percent overall margin, which again, depending on your views, would be higher relative to say other facilities that you've considered today.

The second piece of this is a distributional component that says within that pool of money that's funding an overall 5 percent margin, you've got a significant disparity between freestanding SNFs who are going to be somewhere in the 9 percent range and hospital-based SNFs who even after we take into account cost allocation would have margins on the minus 20 percent range. So an update of something on the order of market basket minus one, which might be consistent with a 5 percent overall margin, could then be distributed as no update to freestanding facilities, an adjustment to the base, and a market basket increase for the hospital-based facilities.

But it's two pieces here. One is to make sure the pool of money is appropriate. The other is to do a distributional issue analogous to what you did with hospitals.

MS. RAPHAEL: I wanted to make three points. First of all, I think our recommendation needs to start with reiterating something on the classification system. Because unless we deal with that and get an effective classification system, how are we ever going to get out of this bind? We're going to have to put Band-aids on the system until we somehow have something that's a

credible way of classifying and measuring resource utilization. So I would like to start with reiterating something in that vein.

And I don't remember now how complicated it is to do this, but actually we have managed to do classification systems for home health care. We managed to do one for rehab facilities. So this is something that seems to me to be doable, if the intensity and focus is on it.

Secondly, on the issue of total margins, and we said earlier that we want to look at that through the filter of access. In your text you refer to one access study, and only one, which I believe was the OIG study of access. Or two of them.

But basically, I'm interested in what we know about access. I think I remember, and I'm not sure I got this right, that in general there was a sense that patients could be placed except for about 1 to 5 percent. But I want to know who's in that 1 to 5 percent, because I think we need to look at who might be the ones who were having some access issues.

And thirdly, I'm interested in this notion of what the different product is in hospital-based facilities. I understand the case-mix difference. It seems to me that for product we're using a proxy of more staff. I mean, that's what I gather. But I'd like to better understand exactly what we think the product is that's different in a hospital-based facility from your average freestanding facility.

And one last comment, I also was wondering if you had any observations about the extent to which hospitals might be exiting this business, as they're exiting physician practice business, as they're exiting home health care, not only because of what happens in this particular business but because they have to focus more on what they consider their core business in a much more turbulent and difficult environment. And therefore, they're shedding what they consider less than central to their current business imperatives.

DR. KAPLAN: Let me address your questions. First of all, I agree with you that we should reiterate the recommendation on classification system.

As far as the difficulty of doing classification system, CMS was mandated by BIPA to study alternative classification systems for the skilled nursing facilities and report on them to the Congress in January 2005. CMS plans to do that, but there doesn't seem to be any sense of urgency in getting a new classification system, first of all. I would say that yes, they have done other classification systems, but there's been will to do that.

Then the issue about a different product. Let me just say that we considered that there is a different product, that half the length of stay and almost double the skilled nursing in the hospitals compared to the freestanding SNFs. In this 10 percent that we are adding to the hospital-based, we really did not consider an addition for product. That 10 percent is more

related to the case-mix different, those 11 points difference in case-mix.

So yes, we considered that there appeared to be a difference in product, but we didn't necessarily give them the money to cover a different product.

As far as the OIG studies, they really are the only access studies out there. But they are pretty decent studies. They talked to the discharge planners which, since all SNF patients are post-hospital, that would be the logical person to talk to.

You were right that 1 to 5 percent had difficult placing patients and that these patients were the most costly patients. I think that this goes directly back to the case-mix and the fact that you have people who are using a lot of non-therapy ancillaries, as they're called, the non-rehab ancillaries. And that even that 20 percent bump that was given those medically complex patients did not really compensate SNFs for those patients. And so they were unwilling to take them.

Does that answer all your questions?

MS. RAPHAEL: Except the only other thing I was just wondering, do we know anything at all about the motivation of the hospitals existing the business? Because I think that's a very important number and we need to understand what's the reason for hospitals existing and to what extent are they exiting all supposedly non-core businesses. I mean, I know hospitals might define that differently. And to what extent is it really due to what they think is inadequate payment.

DR. ROSS: Carol, there's also a lot of other payment policies that have changed. For example, the transfer policy being the big one.

DR. KAPLAN: I can't answer your question. I think that would be a really interesting study to do, but I'm not really sure that when we come down to prioritizing staff's time that it really is something that you'd want to do in the future. If it's something you think is really important to investigate, but I don't think we really do have any idea.

DR. NEWHOUSE: Since I assume you're going to bring us back language to look at tomorrow, let me suggest that we split this recommendation into two and that it go along the lines that Murray said, which I think is a relatively clear statement that the first recommendation deal with the total dollars in the system and the necessity for add-on Z, which we would spell out as the specific add-on needs to stay.

And then the second recommendation deal with the distribution between freestanding and hospital-based facilities. I think we've just tried to pack too much in here, in addition to a lot of code words.

I wanted to comment also on a substantive point about total margins and Medicaid deficiency. I agree with your point, Sally, about if Medicare puts more money in the states may pull it out. In addition to that, am I not right that the Medicare shares

averages around 12 percent?

DR. KAPLAN: That's correct.

DR. NEWHOUSE: Then it's sort of, the Medicare tail can't wag the Medicaid dog. I mean, if we're trying to make even minus 2 percent back to zero, we're talking about a 16 percentage point increase in the Medicare margin. That doesn't seem to be in the cards, in addition to all the distortions that would cause. I think that's not a fruitful line to pursue.

DR. STOWERS: I was just going to echo, I think the number one part about Z needs to be separated out. But I think to be consistent with our previous recommendations, rather than say freeze the base payment amount for freestanding, we'd be better to say for freestanding skilled nursing facilities a market basket update or whatever is not necessary. Saying that we're going to freeze it is different from what we did with the dialysis.

And then just take the last part for hospital-based and say we need a 10 percent increase in the base plus market basket and that's it. But if we're going to be consistent, instead of saying freeze, that has that permanent connotation to it again.

DR. ROWE: Can I ask just a technical question? When we're talking about -- I guess it's relevant to hospitals but moreso here because more of these are for-profit. When w talk about these margins, are these pre-tax or after tax?

DR. KAPLAN: Pre, I believe. Boy, I'm trying to remember the cost report. I believe it has to be pre, but I can hopefully come back with that tomorrow morning.

DR. ROSS: In a minus 2 percent world, it's not clear what the issue is.

DR. ROWE: No, but in a 9 percent world before tax is 5 percent after tax, and it's just a different number. We have this illusory corridor that we think is the right comfortable corridor, and we were talking about sustaining financial stability and creditworthiness, et cetera. What is, in fact, the profitability? I just wondered whether these are before or after tax numbers, because it makes a big difference.

MR. HACKBARTH: Sally, I think we're done for today. How do you feel about that?

DR. KAPLAN: Thank you very much.

MR. HACKBARTH: So I think the bottom line is there seems to be agreement on the content but concern about the structure of the recommendation.

DR. KAPLAN: Okay, and I'll come back tomorrow morning with revised recommendations.

MR. HACKBARTH: Thank you. The last item for today is home health services. Sharon?

* MS. BEE: This presentation is primarily a discussion of the draft recommendations following just a brief review of the analysis that we've done.

First, I'll discuss the background for this sector, which

I've repackaged in response to your direction from the last meeting, to emphasize the somewhat wild ride that home health has had over the last 15 years. Next, I'll review market conditions that we've been discussing for the last couple of months. And finally, we'll look at some more draft recommendations.

From 1987 to 1999 there was a rapid rise in use. For this sector, spending grew from $2 billion to $17 billion. The growth was driven by weak incentives for cost containment and the increasingly long-term care nature of the services delivered.

This growth prompted Congress and the administration, in the mid-90s, to take action to rein in home health. They implemented a series of new policies. The payment system was changed from the cost-based system to the interim payment system in 1997. Then it was changed again from the interim payment system to the prospective payment system in 2000.

During this time, eligibility also changed somewhat. Beneficiaries whose only skilled care need was the drawing of blood no longer qualified for the benefit. Also during this time Operation Restore Trust was initiated to reduce fraud and abuse.

In the wake of these changes came a dramatic decline in use and spending. Spending fell by half from 1997 to 1999, reflecting a decline in both the proportion of beneficiaries using home health and the amount of services home health recipients were using.

Given the recent changes and a somewhat bumpy ride for this sector, payment stability for 2003 may be appropriate. By 2000, the intent of the changes made in the mid-90s seems to have been substantially met. Both beneficiaries and providers could benefit from allowing the system to settle down for a period.

Why here? Well, current market conditions provide no evidence of disparity between payments and costs. Entry and exit in this relatively fluid sector have been stable for the last two years. Reports on access to home health services for beneficiaries from hospitals, nursing homes and the community all seem to indicate good access.

And lastly, without a clear definition of the benefit and clinical standards, we have a limited ability to interpret the changes in use that we can observe.

Which brings us rather quickly to our draft recommendations. As a theme for all three of these recommendations we have a mix of what we know and what we do not know. There are two versions of draft recommendation one on the screen for your consideration.

As a matter of commission policy, and to be consistent with our analytic framework, you could recommend an update equal to the forecasted increase in input prices in the absence of compelling evidence that costs would change at some other rate. However, we note that the uncertainty in this sector is far greater than the other sectors. We have no useful data about costs under this PPS.

Given the high level of uncertainty, there's no evidence

that endorsing the update in current law of market basket minus 1.1, rather than introducing yet another change, is inappropriate.

Draft recommendation two addresses the so-called 15 percent cut. You could recommend the elimination of the cut. This would suggest that the work of the BBA's changes in the mid-1990s is substantially done. We would make future corrections to payments through our update process. Eliminating the cut removes the uncertainty about its implementation and allows policymakers and providers alike a better idea of what's coming for payments in this sector for the future.

We could recommend postponing the cut. We've suggested in this draft recommendation a two-year postponement in response to your input from the last meeting. We will not know much more about the fundamental questions of payment adequacy at this time next year. Postponement would allow time to receive and analyze some cost data from the PPS. It avoids shock to the system of implementing the cut and maintains a tool to reduce spending substantially if appropriate. However, the postponement prolongs the uncertainty of the cut.

Draft recommendation three. As we've discussed in past meetings, we do not have evidence that rural access currently is impaired. In the OIG's study, hospital discharge planners had no greater difficulty placing beneficiaries in home health than their urban counterparts. However, use declined significantly more quickly in rural areas than in urban from 1997 to 1999 and the proportion of exiting agencies in rural areas was greater than urban. Given the uncertainty, a time limited extension of the rural add-on payment may be appropriate.

With that brief discussion, we can open up input for the draft recommendations. Any questions?

MR. HACKBARTH: The crux of the problem here is we don't have cost information, the benefit is ill-defined, there are not clinical standards as to appropriateness, and so we're cut loose from all of our usual moorings and just sort of bobbing about on the sea.

MS. BEE: In our new analytical framework what we've done is we've tried to give ourselves new tools other than margins, other than just relying on some of the cost and the payment data. And we have looked at those. While I wouldn't describe us as on the most solid ground, we have some footing here.

MR. HACKBARTH: Fair enough. I stand corrected. So at least we can say there isn't any gross evidence of access problems, but that's all we can say at this point.

MS. RAPHAEL: We do know about exit and entry because that's as I recall during cost base there were three new entrants for every departure. And then, when we went to IPS there were eight who left for every one who came in. And now it's pretty stable, at about 7,000.

DR. NELSON: Do either you, or perhaps Carol, know how many

areas are down to a single home health provider and which choices formerly were present? Perhaps choices that might be more cost efficient or convenient for the patient.

MS. BEE: We're a little limited in our ability to interpret the data there. GAO did a study to look at the question of the availability of providers. We're always a little bit limited in this area because our official numbers count parents and not branches. So there could very well be a branch of an agency and we would not be aware of it from the way we count their heads.

When GAO looked at the issue for rural areas, especially where you might be concerned about a single agency, in a very high proportion of the counties that our data indicated had zero or no agencies, they found up to three serving the county.

The service areas of the agencies are not very well defined again by our data, so it's very difficult for us to know where that situation might exist.

DR. REISCHAUER: Sharon, just the information you've provided us and a desire to be prudent I think would suggest that we go with the full market basket.

I also would be opposed to postponing the 15 percent cut for two years because I don't think there's any indication at all that we're, in a sense, overpaying by something close to 15 or 10 percent. We'd see expansion in the industry. We'd see something going on.

I mean, we might not be right on, but we can take care of that two years from now when we look and say are payments adequate in the base and make a little adjustment there, rather than holding out this threatened club for another two years. So I would go full market basket and the first half of recommendation two.

MR. FEEZOR: I guess I was going to ask a question that Bob's recommendation would make moot. Is there any indication what a 15 percent reduction would do to access? I guess that's the question I'd have.

DR. ROSS: Sharon, would you first clarify that it's not really 15 percent. We use that because that's what's in law, but it is not numerically 15 percent.

MS. BEE: Our best estimate is that the actual reduction would be between 6 and 8 percent reduction to the base.

MR. FEEZOR: Do you have any indication what impact that will have or would have?

MS. BEE: I don't know.

DR. WAKEFIELD: I agree with Bob and Allen -- I think Allen was agreeing with Bob -- with regard to the first two recommendations, and I'd like to comment on the last. That is the extension of the 10 percent rural add-on payment for two years. A couple of comments about that.

First of all, in our June report, I think that some of what we said there was I believe similar to what you've just said. That is, we have a lack of data, there's a need for data

collection and analysis to see what's really going on with those facilities. And we still don't have that data. Or if we've got it, I missed it. Or we don't have much of it. So that need, I believe, still exists.

Secondly, I'm a little concerned about what those beneficiaries are getting in rural facilities. When I went back and looked at that section of our June report, it said for example that even when you have similarities in diagnosis and functional status between urban beneficiaries and rural beneficiaries, what rural beneficiaries are getting is not the same service as their urban counterparts. And that in fact, it seemed that if those rural beneficiaries were geographically located in urban areas they would, on average, be getting those more intense services. So in other words, if you looked at the population that had no differences in diagnosis or functional status, the level of intensity of services already is different.

Now one might say maybe the beneficiaries in urban areas are getting too much service, or more service than they need. But the point is there is a difference, even when you hold constant diagnosis and functional status. So there's something going on there that I don't know that we fully understand.

The last point I wanted to make about that particular recommendation is that, as you indicated, we've got a very significant more rapid decline in proportion of beneficiaries using home health in rural areas than in urban areas. And that the rate of exit of agencies in rural areas is proportionately much greater than their urban counterparts. But we counter that in the text with GAO's finding that there doesn't seem to be a problem with placing Medicare beneficiaries in either rural or urban areas.

So I guess what I might say that that might suggest is that 10 percent -- because I don't know that we know any better -- that 10 percent rural add-on, in fact, might be just about right. Clearly, the trend in rural areas doesn't seem to be with that 10 percent add-on driving increased utilization. So it may be that -- although again, we don't have much data to work with here, but it seems to suggest that maybe that 10 percent is supporting some adequate access or ability to place Medicare beneficiaries in home health. Or maybe they're getting their home health services at a great distance from where they live. We don't know.

So there's just a lot we don't know here and clearly there have been huge shifts, especially in rural home health. So it's a concern to me, in terms of access for rural beneficiaries.

MR. HACKBARTH: Are we ready to move to voting?

MS. BURKE: I just have one. Just following up on Bob's point about the second recommendation regarding the payment cut. I was just going back through the text again.

As I recall having read the text of the report, it repeatedly stated throughout there was no indication that there was an overpayment, that the payment was too high. At least,

that's how I read this. Am I misreading what you said?

Basically, first of all, you said we don't know very much. Then you went on to say that what we know is that we don't believe, given what we know, that the payments are not appropriate. I believe you specifically say, when you talk about the payments to cost. You talk about volume and what's happened in terms of the frequency of visits which have continued to decline a bit, not certain why, not certain whether quality has been affected. The entry and exit seems to be relatively stable. Your comment, at one point, in discussing the recommendations are that these folks have gone through a series of seismic changes in the last few years, which we may or may not want to have more seismic changes occur.

But I wonder, having said all of that, Bob's point about let's just go ahead with the scheduled reduction seems to fly in the face of the content. Or not?

Oh, I thought you said to go ahead.

DR. REISCHAUER: No, I said eliminate it permanently.

MS. BURKE: Never mind. We're in the same place. I thought you said to go ahead, I'm sorry.

For that reason, I support everything Bob has just said.

MR. HACKBARTH: I think we're ready to vote. What I'm going to suggest is that we follow Bob's lead and vote on the first draft recommendation one. Are people okay with that?

The recommendation on the table is Congress should update home health payments by market basket for fiscal 2003.

All opposed?

All in favor?

Abstain?

On draft recommendation two, again we'll go with the first alternative. The Congress should eliminate the payment cut scheduled for October 2002 in current law.

All opposed?

All in favor?

Abstain?

And draft recommendation three, Congress should extend the 10 percent rural add-on for two years.

All opposed?

All in favor?

Abstain?

Okay, thank you Sharon.

MS. NEWPORT: Murray and I had a brief sidebar here about what all of this will cost when you add it all up. What it means for me at least, the question has more to do with what the Congressional process is and how CBO will score this. I guess we'll know more about that next week.

I was wondering if perhaps the staff could share with us, once we have that, what this means in real money. I'm just interested from a lot of standpoints, in terms of how it affects overall payment.

DR. ROSS: We'll try to get you what I can. My remark about baselines was some of these things -- I suspect, for example, the physician fee recommendation will cost something different in two weeks on the budget scorecard than it would cost today.

I honestly don't know on the issue of the SNF payment because I don't know what is being assumed in baseline about whether CMS will or will not eliminate that money -- excuse me, propose the refinement.

MS. NEWPORT: To the extent that you can reasonably give us a report on that, I think that would be helpful.

DR. NELSON: It isn't so much new money. A lot of this is restoration of old money.

DR. ROSS: That's not how it gets scored.

MS. NEWPORT: I would agree with you in some respects.

MR. HACKBARTH: It's now time for public comment. Let me remind people of the ground rules, for those of you who weren't here this morning. We'd ask you not to read written statements. Please keep your statement brief. And if we find that people from the same field are repeating comments, I'm going to reserve the right to cut off the conversation so that as many people as possible can get to the microphone.

Assessing payment adequacy and updating Medicare payments, continued: outpatient dialysis services, skilled nursing facility care, home health services - January 17, 2002

DR. KAPLAN: I'm here with the three recommendations you asked that we redraft. The first recommendation I've given you two options, but actually I think the first option is the better option. The other one was an --

DR. ROSS: Sally, do we have these?

DR. KAPLAN: In copies? No, I didn't bring copies. I'm sorry. This is basically the recommendation we had last year. The Secretary should develop a new classification system for skilled nursing facility care.

DR. NEWHOUSE: What's the second bullet?

DR. KAPLAN: The second bullet was an effect of my creative last night. I'd really rather not go with it, if that's okay.

DR. ROSS: A smothered verb version of the first.

DR. KAPLAN: It just says, the Secretary should expedite development of a new classification system for skilled nursing facility care. I think if you wanted to have them expedite you could just modify the first one by saying, as soon as possible, or something on that order.

MR. HACKBARTH: I think the first one is fine, and the accompanying text would say something to the effect that we realize that the refinement of RUG-III is underway. We want to be clear though we don't think that that is sufficient and we need a whole new system.

DR. KAPLAN: Right, exactly. Draft recommendation two, if

the Centers for Medicare and Medicaid Services refines the resource utilization group version three (RUG-III) and the temporary increase implemented to allow them time to refine it expires, the Congress should retain this money in the skilled nursing facility base payment rate.

MR. HACKBARTH: Any questions about that?

DR. NEWHOUSE: Could we strike, them?

DR. REISCHAUER: You sort of put it out as a possibility that the first clause could occur and the second one could or couldn't. Is that in CMS' discretion?

DR. KAPLAN: My understanding is it's not, and Murray actually confirmed that with one of the management folks at CMS who said that when the RUGs are refined, the add-on will go away.

MR. HACKBARTH: Why don't we just say then, causing the temporary increase to expire?

DR. REISCHAUER: Yes.

DR. KAPLAN: Okay.

MR. SMITH: Wouldn't it be clearer if we changed retained to add? Just sequentially, at the point that it goes away, it's not there to retain. We're really asking that Congress appropriate funds to increase the base rate by an amount equal to.

DR. ROSS: The point here was to stress that the money is in the payment now. We're trying to keep that amount of money. This isn't a suggestion to put new money in.

MR. SMITH: I don't want to play editor here, but you can't retain it if it goes away. You don't need to retain it if it doesn't go away. We're actually asking that Congress appropriate money equal to the current add-on and add it to the base rate.

MS. BURKE: No, you do not want to be in a situation where anybody thinks there is a cost implication to this. You do not want OMB or CBO to do a base adjustment estimate. We don't want even to suggest that that money went away and came back.

MR. SMITH: I understand the concern, Sheila, but they will.

DR. REISCHAUER: If the baseline is done right, it disappears.

MS. BURKE: The point is we don't want it ever to have gone away.

MR. SMITH: Correct.

MS. BURKE: And to be added back.

MR. HACKBARTH: I could personally live with the word retain. I think it needs to be clear in the text though that there is a redistribution here. One of the implications of retain is it stays where it was, when in fact, as I understand it, it wouldn't. It just goes -- the same amount of dollars is now spread differently across all of the rates. So I think that implication needs to be clear.

DR. ROWE: Can we just say that the base rate should remain the same; should not be changed?

MR. SMITH: It's currently an add-on.

DR. KAPLAN: First of all, it's not in the base now, but

when you say you retain this money in the base payment rate it seems to me that you're saying, keep the money, put it in the base payment rate.

MR. HACKBARTH: We could say, put the same amount of money into the base rate.

MR. MULLER: Just say, the temporary increase implemented to allow -- should be kept in the base rate.

DR. NEWHOUSE: It's not there now.

MR. HACKBARTH: It is transferred to. But the distributive implications are quite different. We're taking money that was going disproportionately to the hospital-based SNF and now it will be spread across all types of SNFs as I understand it.

DR. KAPLAN: No. It really was not. It was pretty much spread among all, pretty much had the same distribution.

MR. SMITH: Glenn, what if we said, Congress should allocate an equivalent amount of money to the skilled nursing facility base payment rate? Congress has to act here. I understand Sheila's desire to avoid the verb appropriate. But Congress has to do this. CMS can't.

MR. DEBUSK: Then retain, that's a pretty good word.

DR. STOWERS: Could we use transfer to the base rate?

MS. RAPHAEL: I like the word retain, and I might even flip it and say, the Congress should retain money from the allocated skilled nursing facility base payment rate even if the Centers -- that's what we're really saying -- even if they declare refinement accomplished.

DR. KAPLAN: So you would put the last phrase first, in other words, rather than starting out with the clause, if the Centers?

MS. RAPHAEL: Yes.

MR. HACKBARTH: David, the Congress will do what it has to do, given its procedures and baselines and all of that. The implication of retain though is consistent with our thinking about, these are existing dollars that we don't want to go away; we simply want put in the base rate. Then Congress will have its rules. I do think it explains our intent.

DR. KAPLAN: The third recommendation, for fiscal year 2003, the Congress should update skilled nursing facility payments as follows: for freestanding facilities, update payments by 0 percent; for hospital-based facilities, update payments by market basket, and increase payments by 10 percent until an effective classification system is developed. Then the text would discuss, again, that refining the RUGs is not an effective classification system. That we're talking about a new classification system.

MR. DEBUSK: My question is, this market basket, you know when you don't receive the market basket in a given year, it's gone. It's gone. Why did we put this market basket in here? It's put in there to anticipate increase in cost from year to year. And you go back and I think this takes somewhere around that number of $60 per patient day, and X and Y takes about $32,

a little over half of it. Here, because the RUG system is inadequate, we put Z in place to take care of that.

Well, our data is 1999, and we can't help that. We understand that now. But in coming forward we've got a performer that says here's really what it is possibly going to look like -- and it's a weak performer at best. Then we come along and say, you're not entitled to the market basket. That don't make sense why you continue nailing this thing when that market basket is put in place to cover these shortages.

MR. HACKBARTH: The crux of the issue, Pete, is that the staff's best estimate, which I have no reason to disagree with myself, is that the freestanding SNFs will have a 9 percent margin on their Medicare business. If we follow the logic that we did for every other provider, it is appropriate to say, they should not get a market basket increase, in my judgment.

Now the unique or somewhat different aspect of this issue that's been raised is that the total margins for SNFs, including their Medicaid business, are minus. Reasonable people can disagree about whether there is an imminent risk to Medicare beneficiaries from that minus 2 percent overall.

We discussed the issue yesterday though and the view of the Commission as a whole, if not every individual member, was that that was not a sufficient basis for saying that we ought to give them the market basket on the Medicare side. Could be the right answer, could be the wrong answer, but it was the answer we came up with, and I don't think that continuing the discussion of it is going to be productive. So your point is understood, well articulated, but there's just not agreement.

MR. DEBUSK: I wanted my last shot.

DR. REISCHAUER: This recommendation is premised on the previous recommendation being adopted, and I wonder if we need to say that somewhere.

DR. KAPLAN: I don't really know how that would be handled, but I'm assuming that that certainly could be discussed in the text.

DR. REISCHAUER: It certainly should be in the text, at a minimum. But it's sort of stark, the zero market basket for freestandings, and you say, whoa. But what you don't realize is that relative to current law we're chucking in a significant amount of money.

DR. ROSS: We assume the Congress takes all of your advice.

MR. HACKBARTH: In this case I think Bob's right. It's worth highlighting that the two are linked.

DR. KAPLAN: Yes, they are linked.

MR. HACKBARTH: Are we ready to vote?

DR. NEWHOUSE: Do we want to add something like, in conjunction with the prior recommendation here then to explicitly link them?

MR. HACKBARTH: As far as I'm concerned we can leave that to the staff. I could either have a lead-in clause or just leave it

to the text. Why don't we let them look at the whole package?

Are we ready to vote? Put up the first recommendation, please. So we're talking about the first bullet here, right?

DR. KAPLAN: Yes, that's correct. The Secretary should develop a new classification system for skilled nursing facility care.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

DR. KAPLAN: The second recommendation now reads, if the Centers for Medicare and Medicaid Services refines the resource utilization group, version III, (RUG-III) causing the temporary increase implemented to allow time to refine it to expire, the Congress should retain this money in the skilled nursing facility base payment rate.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

DR. KAPLAN: And number three reads, for fiscal year 2003, the Congress should update skilled nursing facility payments as follows: for freestanding facilities, update payments by 0 percent; for hospital-based facilities, update payments by market basket, and increase payments by 10 percent until an effective classification system is developed.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

Okay, thanks, Sally.